MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (x) No
Requestor's Name and Address Active Behavioral Health, LLC 6300 Samuell Blvd., Suite 112 Dallas, Texas 75228	MDR Tracking No.: M4-04-3061-01 TWCC No.: ___ Injured Employee's Name: ___
Respondent's Name and Address Texas Mutual Insurance Company Box 54	Date of Injury: ___ Employer's Name: ___ Insurance Carrier's No.: 99D0000334547

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
04/15/03	04/15/03	90915	$120.00	$120.00
04/15/03	04/15/03	90906	$120.00	$120.00

PART III: REQUESTOR'S POSITION SUMMARY

Provider submitted a new Table of Disputed Services indicating the only CPT codes and date of service in dispute is 90906 and 90915 for the date of service 04/15/03.

Requestor states in their position statement carriers "response shall not address new or additional denial reasons or defenses after filing of an initial request."

Carrier denied services as, "The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(D)."

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent's response is untimely.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The carrier denied services fair and reasonable. The MFG has a $2 per minute for CPT code 90906 and documentation supports delivery of services per MFG MGR II (F) and reimbursement is recommended.

CPT code 90915 is a DOP procedure, carrier made no reimbursement, denying services as fair and reasonable. Documentation submitted by the requestor supports delivery of services per MFG MGR II (F) and reimbursement is also recommended.

Therefore, reimbursement is recommended for the date of service 04/15/03.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
				Total Left Column:			$0.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $240.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Michael Bucklin	12/20/04
	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____